

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

11297
Do not use this space.

APR 19 1939

1. PLACE OF DEATH

(a) County LACLEDE Registration District No. 449
(b) Township 1 Primary Registration District No. 4267
(c) City LEBANON (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 60 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

NANCY C. VERNON
(a) Residence, No. 303 N. JEFFERSON St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOW
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. A. VERNON
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAR 21 - 1857
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 11 19
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Home wife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DALAS CO. MO.

FATHER 13. NAME JAS. FORD

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) TENN

MOTHER 15. MAIDEN NAME Un known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Mrs. Chas. Vernon Lebanon Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Lebanon Mo. DATE Mar 12 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Roberts Lebanon Mo.

20. FILED 3-11-39 J. H. M. Couch Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAR. 10 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1939, to Mar. 10, 1939
I last saw her alive on Mar. 10, 1939. Death is said to have occurred on the date stated above, at 5:10 P. m.
The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia Date of onset Feb. 27, 39

Other contributory causes of importance: 108

Name of operation none Date of _____
What test confirmed diagnosis? Physical exam. Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) P. A. ..., M. D.
(Address) Lebanon Mo.

RECEIVED
District Health Officer No. _____
District File Number 7-39-S-15
Date Filed 4-12-39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed *R. A. Palma*

Licensed Embalmer No. 1161

P. O. Address Lebanon Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.